TriCircle, Inc.
AUTHORIZATION TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize TriCircle, Inc. to:
Patient Name (Print)

Release my medical history information and/or treatment records relating to substance abuse treatment and/or psychiatric condition(s) to the following physician/therapist/treatment program:

(Name) _____

(Address)_____

(Phone & fax)_____

Obtain my medical history information and/or treatment records relating to substance abuse treatment and/or medical and/or psychiatric condition(s) from the following physician/therapist/treatment program:

(Name)_____

(Address)_____

(Phone & fax)_____

This information is for the following purposes (any other use is prohibited): ongoing treatment planning and coordination of care. This includes both verbal and written communication, substance abuse and HIV related information. **This authorization will expire 3 months from the date of termination of services.**

I understand that:

- I may revoke this authorization by delivering a written notice in person to by mail to my Clinician, except to the extent information has been released in reliance upon this authorization.
- In most cases, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- My alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act of 1996 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to authorize release of any information by withholding my signature.

Patient Signature _____Patient Name (Print) _____

Date_____ Date of Birth_____

Witness_____ Date_____ Rev. 11/20